

State of Wisconsin

BadgerCare Waiver Extension Request

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**Wisconsin Department
Of Health and Family Services**

**Helene Nelson
Secretary**

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Introduction

During the decade between 1987 and 1997, Wisconsin was a national leader in the area of welfare reform. Based in part upon the welfare reform efforts in Wisconsin, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which dramatically transformed the nation's welfare system. Following passage of welfare reform in Wisconsin in 1997, Congress passed the federal Balanced Budget Act containing a ten-year \$40 billion program known as the State Children's Health Insurance Plan (SCHIP). The intent of this federal program, also known as Title XXI of the Social Security Act, was to expand health insurance coverage to uninsured, low-income children. The program was designed to give states flexibility to create individual programs to provide health care coverage to low-income children. It was this federal legislation that allowed for the creation of BadgerCare.

The SCHIP program provided states with an opportunity to create new programs to insure low-income children, or to expand individual Medicaid programs to cover low-income children. Employing this new federal flexibility granted under the SCHIP legislation, the Wisconsin Legislature, through the 1997-99 state budget (1997 WI Act 27) authorized the creation of BadgerCare under §49.665 of the Wisconsin Statutes. BadgerCare was created as an expansion of the State's Medicaid program.

In January 1999, Wisconsin was granted a federal waiver to implement BadgerCare under Title XIX as a section 1115(a) demonstration program. The Wisconsin BadgerCare program (project No. 11-W-00125/5) began enrollment in July 1999.

In January 2001, Wisconsin received approval from the Centers for Medicare and Medicaid (CMS) to amend the BadgerCare demonstration project under Title XXI. This waiver amendment allowed Wisconsin to cover parents of low-income children under Title XXI funding rather than under Title XIX. This amendment allowed Wisconsin to cover parents enrolled in BadgerCare at a 71 percent federal match rate. Prior to receiving this amendment, Wisconsin was only permitted to claim a 59 percent federal match rate for parents.

The Division of Health Care Financing in the Wisconsin Department of Health and Family Services administers the BadgerCare program.

This document, in part, constitutes Wisconsin's request for a three-year waiver extension for the Wisconsin BadgerCare program.

Supporting Documentation

1) BadgerCare Objectives

This section reiterates the objectives established at the time BadgerCare was proposed.

BadgerCare was created as a health insurance program for low-income working families with children. The concept behind BadgerCare was to provide health care coverage to families with incomes too high for Medicaid and yet still did not have access to health insurance. By extending health care coverage to uninsured low-income families, BadgerCare sought to provide a safeguard against increasing the number of uninsured families and children as a result of Wisconsin's welfare reform efforts.

Further, policy makers created BadgerCare with the understanding that many families who join the workforce have access to affordable, employer-provided health care. However, for others, it was considered that the lack of access to health care could be a disincentive to work. Therefore, BadgerCare sought to bridge the gap between low-income Medicaid coverage and employer-provided health care coverage.

BadgerCare aided Wisconsin in the effort to reform the cash-based welfare system. Over the nearly four years of BadgerCare enrollment, Wisconsin has achieved measurable success in reforming its welfare system. As a result of successfully moving people off welfare, BadgerCare has now become a safety net for low-income families with children, many of whom have never been enrolled in Medicaid.

According to the 2001 Wisconsin Family Health Survey, only 4 percent of the estimated 2,221,000 households in Wisconsin had no health insurance of any kind in the previous 12 months. On a national level, since the beginning of BadgerCare, Wisconsin has consistently ranked among the top states in the nation for having the least number of residents without health care insurance. In fact, according to the Kaiser Family Foundation, Wisconsin currently ranks sixth among states with the lowest level of uninsured population.

As of February 2003, BadgerCare enrolled over 105,300 low-income people. Over 35,228 low-income children now have health care coverage as a result of BadgerCare. Moreover, because federal regulations require BadgerCare applicants to first be screened for Medicaid eligibility, BadgerCare has provided health care coverage to over 71,800 children through the State's Medicaid program.

To qualify for BadgerCare the following requirements must be met:

- Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is at or below 185 percent of the federal poverty level (FPL). Families remain eligible for BadgerCare until their income exceeds 200 percent of the FPL.
- No asset test is required to enroll in BadgerCare.
- Families that currently have, or have had, insurance in the past three months, or who have had access to a group health insurance plan in which their employer pays at least 80 percent of the monthly premium, are not eligible for BadgerCare.
- Most BadgerCare families are enrolled in the Wisconsin Medicaid managed care Health Maintenance Organization (HMO) program. However, BadgerCare can pay premiums to enroll families into their employer-sponsored health insurance. To qualify for the Health Insurance Premium Purchase (HIPP) program, the employer must pay at least 40 percent, but less than 80 percent, of a family premium. In addition, the cost of the family premium, plus wraparound services equal to BadgerCare coverage, must be cost-effective compared to BadgerCare HMO coverage for the family. As of February 2003, 104 families were enrolled in HIPP.

- Families with an income at or above 150 percent of the FPL pay a premium equal to 3 percent of their income.

The graph in Appendix A demonstrates the success BadgerCare has had in extending health care coverage to low-income working people. The graph shows the rapid enrollment growth that occurred in the first demonstration year and reflects the high level of initial interest in the program. In demonstration year two through four, the graph shows the reach of BadgerCare as reflected by steady and continued enrollment growth. Our research of those currently enrolled in BadgerCare demonstrates the following:

- Twenty nine percent of families enrolled in BadgerCare are poor and have income under 100 percent of the FPL.
- Fifty five percent of BadgerCare families are between 100 percent and 150 percent of the FPL.
- Sixteen percent of BadgerCare families are between 150 percent and 200 percent of the FPL.
- Virtually all uninsured children under 200 percent of the FPL in Wisconsin are enrolled in BadgerCare.
- Ninety five percent of BadgerCare parents and children are in working families.
- Almost 40 percent of families in BadgerCare have moved up the economic ladder from Medicaid to BadgerCare.
- Fifty percent of those in BadgerCare do not have family coverage for dependents. No one enrolled in BadgerCare has access to affordable health care coverage where the employer pays 80 percent of family plan cost.
- Over 60 percent of BadgerCare families have never been on Medicaid.

2) **Special Terms and Conditions**

The BadgerCare budget neutrality target outlined in the Health Care Financing Administration Special Terms and Conditions was exceeded by \$18.9 million in total computable funds through demonstration year four, or approximately \$11.0 million in federal funds. The projection through demonstration year five estimates total spending in excess of the targets of \$15.5 million, or \$9.0 million in federal funds. The primary reason for exceeding the budget neutrality was due to the use of a single, blended neutrality target covering adults and children when in fact the actual expenditures covered only adults, a higher cost population.

Coordination With Other Waivers or Programs

The State's Title XXI Children's Health Insurance Program, as approved on May 29, 1998, and amended on December 30, 1998, continues to operate concurrently with the Section 1115(a) demonstration.

Enrollment Limits

Wisconsin residents with a net family income not greater than 185 percent of the Federal Poverty Level (FPL) meet the income eligibility requirement for BadgerCare. Under BadgerCare guidelines an applicant is an individual who has not received Medicaid or BadgerCare in the previous month, or who was not part of a family that was receiving BadgerCare in the previous month. Recipients with a total family income that does not exceed 200 percent of the FPL remain eligible for BadgerCare. Under BadgerCare, recipients are individuals who are receiving BadgerCare in the previous month, or who are part of a family that was receiving BadgerCare in the previous month.

The State has not closed BadgerCare enrollment, instituted a waiting list, or decreased eligibility standards with respect to the approved Title XXI State plan and Demonstration Population 1. No enrollment changes have occurred during the Title XIX demonstration.

Beneficiary Marketing, Education, and Enrollment

All marketing of BadgerCare has been conducted in accordance with CMS' marketing guidelines. The attached marketing brochure illustrates that our BadgerCare material has followed CMS' requirement to have marketing material written in simple form with easily understood prose.

The Department requires that any marketing done by HMOs must be submitted to the Department for prior written approval. This requirement includes marketing material or informing material that is produced by providers under contract with the HMO or owned by the HMO. In addition, the Department prohibits the following marketing practices:

- Practices that are discriminatory;
- Practices that seek to influence enrollment in conjunction with the sale of any other insurance product;
- Direct or indirect cold calls, either door-to-door or by telephone;
- Offer of material or financial gain to potential members as an inducement to enroll;
- Activities and material that could mislead, confuse or defraud consumers;
- Material that contains false information; and
- Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

The following represents a chronology of BadgerCare marketing and outreach efforts employed during the course of the BadgerCare demonstration project.

1) Fall 1997 – Spring 1998

- Planning for and implementation of Medicaid training sessions for local income maintenance agency staff on Medicaid basics and special topics such as AFDC and AFDC-related Medicaid, Healthy Start, Presumptive Eligibility, Deductibles, Institutions, SSI and SSI-related, etc.
- Planning for and implementation of Medicaid training to be delivered to community groups and health care providers on Medicaid program by HMO enrollment contractor, Automated Health Systems, Inc.
- The Department planned and conducted a direct mail campaign to 18,000 families whose AFDC case closed for reasons such as “family request” or “lack of review.” Informational telephone surveys of the larger social service agencies provided information that the mailing did not have a significant impact on Medicaid applications. In addition, caseload data did not show any increase in applications during the time period of the mailing.
- W-2 and Medicaid Brochure, explains the difference between the programs and that Medicaid is an entitlement. Distribution statewide of more than 600,000 brochures and posters in English, Spanish, and Hmong.
- The Medicaid and BadgerCare Recipient Services hotline (1-800-362-3002) was initiated and operated by the state’s fiscal agent. The hotline provided expanded services and evening and weekend hours. In addition to general program information, callers receive assistance in how and where to apply for Medicaid and BadgerCare and obtain help in resolving case problems. Staff at the hotline provide trouble-shooting services and research case-specific problems, including computer systems issues. These services are now available weekdays until 9 p.m. and all day Saturday. The hotline averages about 1,000 calls each day.

2) June 1998 – December 1999

- Outreach grants totaling \$2.3 million to local public health departments to assist uninsured families in gaining access to Medicaid and BadgerCare. Contributions to outreach include these efforts: Healthy Start outreach, “Back to School” initiatives, and outreach targeted to immunization activities.
- Eligibility outstationing grants totaling \$2.3 million to local social service departments to implement a variety of projects. Outstationing proved to be very successful both in terms of increasing participation and customer satisfaction by making the application site and time for Medicaid and BadgerCare more convenient.
- Outreach grants to tribal agencies provided staffing to tribal health clinics to do outreach and benefits counseling to tribal members.
- Wisconsin was an active participant in the National Governor’s Association “Insure Kids Now” campaign, which promotes the states’ health insurance programs for children through national TV and local radio advertising, plus other promotions.

- Special customer service resources, including funding for a community help line and advocacy services in Milwaukee. Advocacy forums to address problems in the delivery system.

3) **Spring 1999**

- A brochure entitled “*Need Help Paying for Your Children’s Health Care*” were distributed in spring of 1999. Distribution statewide of more than 600,000 brochures and posters in English, Spanish, and Hmong.
- A TV ad called “*The Birthday Party*” promoted the importance of health insurance for children in Wisconsin since early 1999. This ad encouraged families to explore Medicaid coverage for their children. The ad was run in all major TV markets in Wisconsin in spring of 1999. Caseload data did not show any increase in applications during this time period.
- As part of an outreach grant from the Department, and in response to demand for customer service in Spanish and Hmong, the Latino Health Organization in the southeastern part of the state (Milwaukee, Waukesha, Racine, and Kenosha) ran Medicaid TV and radio ads in Spanish, radio ads in Hmong. Applications for Medicaid and BadgerCare increased at local community organizations as a result of this effort.
- A Madison-based advocacy organization, ABC for Health, Inc., provided training and technical assistance statewide to community agencies to disseminate the lessons learned from a very successful Healthy Start outreach initiative in three rural counties in the northwestern part of the state. Initial grant resulted in a current Covering Kids grant in the state.
- Medicaid and BadgerCare brochures, fact sheets, and other products were introduced on the Department’s web home page at www.dhfs.state.wi.us. Other additions included caseload information reported both by county, and statewide. This information allowed tracking of monthly participation; and demographic reports describing the Wisconsin population that is below 200 percent of poverty and uninsured, to help inform outreach efforts.
- Additional funding for local social service agencies before BadgerCare implementation allowed for effective local planning to deal with caseload increases.
- Customer service was improved with the connection and training of local social service agency staff on the use of the state Medicaid Management Information System.

4) **July 1999 – December 1999**

- In addition to the statewide services, specialized services for customers in Milwaukee County were offered during the start-up of BadgerCare. Staff at this hotline were trained to mail out application materials to families and to assist families in navigating the eligibility determination system in the Milwaukee County, which

represents about one-third of the statewide Medicaid caseload. This hotline averages 500 calls per week.

- In addition to the Milwaukee specific phone number, the county set up a special unit to process BadgerCare case conversions and deal with start-up problems.
- Starting in July, the Department expanded initial application receipt activities at the Healthy Start sites to include eligibility for family Medicaid and BadgerCare. The sites included all Federally Qualified Health Centers and Disproportionate Share Hospitals throughout the state.
- An ad featuring Wisconsin Governor Tommy G. Thompson introducing BadgerCare was broadcast in the state's five major media markets during July 1999. The ad reached over 90 percent of the target audience, adults ages 25 – 45. During the first three months of BadgerCare implementation the Milwaukee BadgerCare hotline logged over 8,000 calls. When asked how they heard about BadgerCare, about 34 percent responded that they had seen the ad on TV, the single largest response group.
- BadgerCare brochures and posters were distributed with the message that the program provides health insurance for working families. More than 850,000 copies (also in Spanish and Hmong) had already been distributed to a statewide mailing list that included health care providers, public health departments, advocacy and other community organizations, economic support agencies, and school systems.

5) January 2000 – Present

- A second phase of the BadgerCare outreach effort included focusing on school-based outreach, continuation of outstationing, program simplification, establishing a statewide network in conjunction with the Covering Kids agency in Wisconsin, and implementation of program administrative efficiencies that will improve program access.
- In partnership with the Dane County Health Council, the Department implemented a two-year project to improve access to Medicaid and BadgerCare by simplifying applications. Simplification occurred by implementing reduced verification procedures and a mail-in application process. Additionally, we implemented outreach efforts for target groups, focusing on the growing Latino population in Dane County and provided enrollment assistance to other underinsured groups. The project goals have been:
 - Design and test a simplified mail-in application process and reduced verification;
 - Outreach to families from targeted communities who are hard to reach;
 - Design a proactive system to reach families and keep them attached; and
 - Eliminate barriers to application for the customers and reduce workloads for the staff.

Program timeframe

Outreach phase – March 2001 through December 2002.

Simplified application test and evaluation phase – March 2001 through July 2001.

Simplified application processing will continue and be assimilated into statewide simplification when it occurs in July 2001.

Main Target Population

Latino Families

- **Program simplification initiatives.** These efforts (implemented July of 2001) were as follows:
 - Reduced verification requirements to simplify the application and review process and to minimize delays;
 - Simplified application forms – short form is being developed;
 - Expanded use of mail and phone applications;
 - Improved computer-generated notices to reduce confusion and promote informed decision making – requires CARES changes that are under development; and
 - Expanded outstationing opportunities to improve access.
- Expand the scope of work with the Robert Wood Johnson grant in order to build a statewide customer-focused infrastructure to improve local Medicaid and BadgerCare service delivery. The contract (April 2000-June 2002) was with ABC and accomplished the following:
 - Expanded coalition coverage statewide;
 - Implemented Statewide training to compliment AHSI and DES training efforts;
 - Provided Technical assistance for capacity building and project replication;
 - Provided benefits counseling services statewide;
 - Established an inter-active website;
 - Established 20 community sites throughout Milwaukee for benefits counseling and application access to Medicaid/BadgerCare, Food Stamps and ChildCare;
 - Established regional sites (corresponding to Department regions) for benefits counseling and network building using a toll free number;
 - Worked with hard to reach populations, such as migrant families; and
 - Assisted with the monitoring and implementation of a simplified mail-in application process.

Benefits

BadgerCare is a Medicaid expansion program. The Wisconsin Medicaid benefit package is among the most comprehensive and extensive in the nation, offering every optional Medicaid medical service except Christian Science nursing services. A complete list of mandatory and optional benefits and services under the State's Medicaid program is shown in Appendix B.

Most BadgerCare families are enrolled in the Wisconsin Medicaid managed care Health Maintenance Organization (HMO) program. However, BadgerCare can pay premiums to enroll families into their employer-sponsored health insurance. To qualify for the Health

Insurance Premium Purchase (HIPP) program, the employer must pay at least 40 percent, but less than 80 percent, of a family premium. In addition, the cost of the family premium, plus wraparound services equal to BadgerCare coverage, must be cost-effective compared to BadgerCare HMO coverage for the family. As of February 2003, 104 families were enrolled in HIPP.

Families with an income at or above 150 percent of the FPL pay a premium equal to 3 percent of their income.

Prior to receiving a federal waiver, BadgerCare extended Medicaid coverage to all Omnibus Reconciliation Act (OBRA) children through the age of 18 years old in families with income under 100 percent of the FPL. Under provisions of OBRA, however, these children were phased into Medicaid in 2002.

Cost Sharing

Currently, 14.2 percent of all adults enrolled in BadgerCare pay a monthly premium equal to 3 percent of their income. Under BadgerCare guidelines families with income that is at or above 150 percent of FPL are currently required to pay a monthly premium of 3 percent of family income. These premiums are collected on a monthly basis.

The State of Wisconsin's biennial budget (2003 WI Act 33) was signed into law on July 24, 2003. A provision within this budget bill increased premiums for BadgerCare enrollees with income at or above 150 percent of the FPL. The legislation increased the current 3 percent premium to 5 percent, effective January 1, 2004. Premium amounts will continue to be determined based on net income ranges as opposed to exact 5 percent income brackets for each family.

Those in managed care organizations do not have copays or deductibles. Those enrolled in BadgerCare on a fee-for-service basis have the same co-pay requirements as those in the State's Medicaid program.

Delivery Networks

Currently there are 13 HMOs participating in BadgerCare. Approximately 72 percent of all BadgerCare recipients are enrolled in an HMO. The remaining 28 percent receive BadgerCare on a fee-for-service basis.

A person enrolled in BadgerCare must enroll in an HMO if they live in a county where there are two or more participating HMOs. For those living in a county with one HMO, recipients have the option of electing enrollment in the HMO, or obtaining care under a fee-for-service arrangement. Those living in a county with no HMO are covered through fee-for-service. Currently, there are 13 HMOs participating in BadgerCare. The following represents the HMOs in BadgerCare:

- Atrium Health Plan
- Dean Health Plan
- GHC of Eau Claire County
- GHC of South Central Wisconsin

- Health Tradition Health Plan (formerly: Greater La Crosse Health Plans)
- Managed Health Services
- Mercy Care Health Plan
- Network Health Plan
- Security Health Plan
- Touchpoint Health Plan
- UnitedHealthcare of Wisconsin
- Unity Health Plan
- Valley Health Plan

6) **Evidence of Beneficiary Satisfaction**

Wisconsin completed its first statewide CAHPS®¹ (Consumer Assessment of Health Plans) Enrollee Satisfaction Survey in 2000. This was the first time Wisconsin conducted the survey, and therefore represents the baseline with which future CAHPS survey results will be compared. The first survey showed that consumer satisfaction with key aspects of care and service provided by HMOs in the Wisconsin Medicaid/BadgerCare program exceeded NCQA-reported national averages in all areas but one.

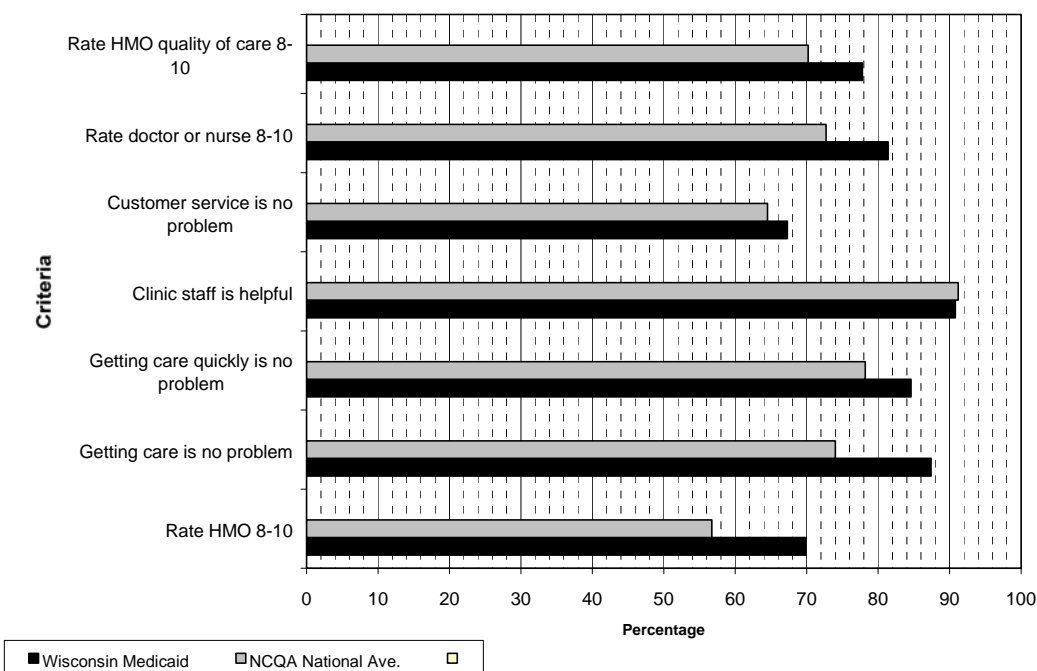
To allow for some frame of reference, Wisconsin compared its results on key indicators with results achieved by HMOs nationwide reported in the NCQA® *State of Managed Care Quality 2000*.²

Chart 1 below summarizes those results.

¹ CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. government agency.

² Use of data from the *State of Managed Care Quality 2000* report by permission of NCQA.

Satisfaction: Wisconsin Medicaid HMOs and NCQA National Averages



Since enrollment in BadgerCare had only begun in July 1999, no enrollees met the enrollment criteria for inclusion in the initial survey. However, the HMOs assessed in the Medicaid CAHPS® survey are the same HMOs serving BadgerCare enrollees. The survey did not include fee-for-service delivery system recipients.

Wisconsin has recently completed administering a new statewide CAHPS® enrollee satisfaction survey. This survey includes BadgerCare enrollees, sampled separately from other low-income families with Medicaid enrollees to allow specific analysis. It also provides for sampling of beneficiaries in the fee-for-service system. The final report on the results of this survey will be available in the second quarter of CY 2003.

The full report on Wisconsin's 1999-2000 statewide Medicaid CAHPS® enrollee satisfaction survey may be viewed at the following web site:

<http://www.dhfs.state.wi.us/medicaid1/recpubs/cahps/cahps.htm>.

Enrollee Satisfaction with Behavioral Health/Substance Abuse Care

Access to specialty services for mental health and substance abuse is essential in any health care delivery system. The Medicaid program has an interest in assessing both access to care and quality of care in these important areas. Part of the information required to perform this assessment is available as objective utilization data. Additional important data for the assessment can be obtained from enrollees by means of a survey.

In 1999-2000, an enrollee satisfaction survey was conducted for HMO enrollees with respect to mental health and substance abuse specialty care services. Overall satisfaction with mental health and substance abuse services shows three out of four respondents indicated they were either "very" or "somewhat" satisfied with services. Respondents

indicated satisfaction with the progress of their treatment by a nearly identical margin. Only 6.6 percent of respondents were very dissatisfied overall and only 4 percent indicated they were very dissatisfied with their treatment progress.

Satisfaction with clinic performance was even higher with over 87 percent of respondents indicating they would recommend their clinic to a friend. A nearly identical percentage indicated they were hopeful for recovery. Seventy-eight percent of respondents strongly agreed, or agreed somewhat, that clinics returned calls within 24 hours.

In addition, with eight out of ten respondents indicated they could get an appointment when they wanted one. Fewer than one out of four enrollees agreed that they had to wait too long in the reception area when they had an appointment and three out of four respondents said they got all the care they needed.

7) Documentation of Adequacy and Effectiveness of the Service Delivery System (Including Subcontractor Performance)

Wisconsin's new rapid-cycle performance measure system called MEDDIC-MS, the *Medicaid Encounter Data Driven Improvement Core Measure Set*, includes measures that reflect access to key primary care, preventive care and specialty care services for children and adults in Medicaid/BadgerCare. Profiles of women's health care and children's preventive care for children will be published in 2003 using MEDDIC-MS administrative data.

The table below shows the results of selected MEDDIC-MS access indicators compared to similar measures in HEDIS®.³ While the measures shown below are *similar*, methodological differences require that comparisons be made for *a frame of reference only*. The data include Medicaid and BadgerCare enrollees.

³ HEDIS® the Healthplan Employer Data Information Set is a set of managed care performance measures developed by NCQA, the National Committee for Quality Assurance.

MEASURE	MEDDIC-MS	HEDIS®
Childhood immunizations	Full immunization: 37.1% Substantial immunization: <u>22.3 %</u> Total: 59.4 % Incomplete immunization: 40.5 %	Combo 1 (mean): 51.3% Compare to MEDDIC-MS Total Combo 2 (mean): 38.1% Compare to MEDDIC-MS full
Blood lead toxicity tests	One year olds: 59.9% Two year olds: 47.7%	No measure.
Mental Health or Substance Abuse inpatient stay follow-up at 7 and 30 days after, ages 6-20, 21+	(Age cohorts combined) Specialist: 7 days: 24.4% , 30 days: 48.6% PCP: 7 days: 1.3% , 30 days: 4.7% Unspecified provider: 7 days: 3.9% , 30 days: 6.7%	Mental health diagnosis only (HEDIS does not measure substance abuse after-care) by specialists: 7 days: 34.07% , 30 days: 57.28%
Women's health maternity care	Cesarean Sections: 12.9% VBAC: 8.6% Substance abuse care: 1.9% HIV test: 16.6%	C-sections: 16.57% VBAC: 39.02% HEDIS® has no measure for substance abuse care or HIV testing in maternal care.
Women's health Mammography	Age 40-49: 22.9% 50+: 32.4%	Age 52-69: 53.7%
Malignancies of the breast detected	Age 40-49: 0.5% 50+: 1.9%	No measure.
Pap test—cervical cancer screening	Age 18+: 24.9%	Age 21-64: 57.5%
Malignancies of the cervix or uterus detected	Age 18+: 0.58%	No measure.
Well-child ambulatory care	73.0% of children had one or more well-child encounter. By age cohort: < 1 year of age: 69.9% 1-2 years: 84.3% 3-5 years: 78.1% 6-14 years: 67.5% 15-20 years: 71.2%	By age cohort: 1-2 years: 85.2% 3-6 years: 73.3% 7-11 years: 75.9%
Mental Health and substance abuse services (MEDDIC-MS age cohorts are 0-18 years and 19+)	Mental health or substance abuse evaluation: 3.5% Mental health day/outpatient treatment with a mental health/substance abuse specialty provider: 5.8% Mental health day/outpatient treatment with a PCP or unspecified provider: 3.9% Substance abuse day/outpatient treatment encounter with a specialty provider: 0.2% Substance abuse day/outpatient treatment encounter with a PCP or unspecified provider: 0.4%	Mental health day/night care or ambulatory care by a specialist: 5.66% (all age cohorts) Substance abuse day/outpatient treatment encounter with a specialty provider: 0.84% (all age cohorts)

Care Analysis Projects

Wisconsin Medicaid continues to develop Care Analysis Projects (CAP) and targeted interventions based on systematic data analysis of specific outcome measures. CAP reports provide care management information and support to Medicaid and Badger Care Managed Care Organizations and fee-for-service providers. The goal of CAPs and targeted interventions is to improve care delivery and the health status of Medicaid and Badger Care enrollees by increasing the rate at which enrollees receive recommended preventive and screening services, and closing the gap between recommended treatment and actual treatment.

Asthma and Diabetes CAPs were completed in 2002. HMO-specific reports were provided to the medical director and contract administrator of each Medicaid participating HMO. Wisconsin Medicaid will continue to monitor trends in the quality of asthma and diabetes care management over time. Targeted interventions for asthma, diabetes, and lead screening for one and two year olds were successful and demonstrated that managed care encounter data and FFS paid claims data can be analyzed to identify enrollees in need of clinical intervention.

Plans for 2003 CAPs include completing an Asthma CAP based on 2002 administrative data, and comparing those results to results from 2000 and 2001. In addition, an analysis of the quality of care management for acute myocardial infarction will be conducted. Targeted interventions for asthma, diabetes, and lead screening will continue, along with implementation of a managed care tobacco intervention. Attached in Appendix C is sample CAP report on Asthma.

8) Quality

In addition to the monitoring summarized above involving encounter data-driven standardized performance measures, the State conducts quality audits and case reviews through external quality review.

Wisconsin utilizes an external quality review organization (EQRO) in several roles for both FFS and managed care review. FFS review includes inpatient review of all elective admissions for appropriateness and quality of care. The review concentrates on short stays (less than 48 hours), re-admissions within 31 days, and a random sample of urgent and emergent admission to the hospital. The random sample of urgent and emergent admission review is also provided for MCO enrollees.

Review of all inpatient psychiatric admissions for recipients under the age of 21 years for medical necessity is performed for FFS recipients by the EQRO.

Review of all inpatient admissions for FFS mental health and/or substance abuse treatment for medical necessity and quality of care is provided by the EQRO.

EQRO managed care review includes encounter data validity audits, focused clinical quality reviews, and review of the performance improvement project reports submitted by the HMOs. The EQRO is active in projects monitoring services to BadgerCare recipients in both the HMO program and in the FFS delivery system.

In addition to retrospective quality monitoring, Wisconsin has developed a system to help identify the special health care and cultural needs of new enrollees in the HMO delivery system in order to improve access to appropriate services.

The Department has also developed a Medicaid QI activity tracking database. Projects in the database are updated on a regular basis and this report is generated monthly. The report is used to track and report the progress of identified QI projects. An updated copy of our QI Activity Tracking Report is attached in Appendix D.

New HMO Enrollee Needs Assessment: Identification of Special Health and Cultural Needs

Improving the health of Medicaid/BadgerCare enrollees is the ultimate goal of the managed care program. Achieving that goal is dependent on the HMO and its provider network being able to conduct effective outreach to their enrollees, particularly in the period immediately following enrollment.

HMOs often report difficulty reach out to their Medicaid enrollees due to enrollees frequent relocation, unique cultural or language needs, or periodic loss of telephone service if telephone service is used.

Wisconsin developed a tool called the Health Needs Screening Brief Enrollee Survey in 2001. The state's enrollment broker administers the survey at the point of HMO enrollment by both phone and mail. The data is shared electronically with the HMO to alert the HMO to special health care needs of their new enrollees, facilitate improved outreach by identifying language and cultural needs, alternative contact information and improve linkage of enrollees to services. Attached in Appendix E is the enrollee survey.

HMO Performance Improvement Projects

Performance improvement projects conducted by HMOs are a central part of Wisconsin's quality assessment/performance improvement strategy. These initiatives have a direct effect on population health in the Medicaid/BadgerCare program. Evaluation of performance improvement project reports provides the Department with insight not only into the effectiveness of the interventions being described, but into the sophistication and capability of the HMO's quality improvement program.

Overall effectiveness of HMO performance improvement projects is reflected in the fact that 73 percent of the intervention project reports from 1997 to 2000 resulted in improved performance. However, the number of intervention reports dropped in CY 2000 after trending up from CY 1997 to CY 1999. This occurred as some HMOs repeated baseline studies due to methodological changes or dropped study topics after completing a baseline. This problem has been addressed, in part by the implementation of MEDDIC-MS and its mandatory performance improvement projects in measure areas where HMO performance fails to meet the Department's goal for the measure. In MEDDIC-MS, the rate reported on the measure based on 2002 encounter data is the baseline and the required report must be on HMO performance improvement initiatives.

The Wisconsin Medicaid program currently partners with 13 Wisconsin managed care organizations to bring high quality health care to Wisconsin citizens enrolled in BadgerCare and Medicaid. As part of Wisconsin's Medicaid quality improvement efforts, each HMO is required to conduct two Performance Improvement Projects annually. Each study selects a health care issue of high relevance to Medicaid/BadgerCare recipients and is designed to improve care delivery. These Performance Improvement Projects have the potential to identify "best practices" that can then be reproduced throughout the Wisconsin Medicaid/BadgerCare system.

Each Performance Improvement Project is submitted for review by the Wisconsin Medicaid program. The "best of the best" are then showcased at a "Best Practices Seminar," a public forum for the presentation and discussion of selected studies. These studies are promoted to others as examples of sound performance improvement projects that can impact the quality of care provided to Wisconsin Medicaid/BadgerCare recipients. Attached in Appendix F is a copy of the Best Practices Seminar registration form for the upcoming seminar in May 2003.

9) Compliance with the Budget Neutrality Cap

Budget Neutrality Waiver Terms and Conditions

The terms and conditions stipulate that the phrase "expenditures subject to the budget neutrality cap" include all Medicaid (Title XIX) expenditures on behalf of the adult BadgerCare population under the demonstration. This includes both expenditures for the expansion population in a Managed Care Organization (MCO) and expenditures for individuals receiving services in a fee-for-service setting.

The terms and conditions further stipulate that the calculation of the budget neutrality limit will be based on trending the Wisconsin 1999 calendar year aggregate Per Member Per Month (PMPM) cost estimate of \$121.23 forward at an annual rate of 3.48 percent.

The State is requesting an amendment to the five-year demonstration project. This amendment would change the budget neutrality target to meet provisions of the Balanced Budget Act (BBA) of 1997 regarding managed care contracts. Federal Regulations (42 CFR Part 438.6) were changed in 2001 to require that managed care contracts have actuarially sound rates. As part of this actuarial soundness, States are required to have rate cells specific to the enrolled population defined by eligibility category, age, gender, locality or region and risk adjustment.

Prior to the new rules contained in the BBA of 1997, Wisconsin's budget neutrality target was a single rate specific to geographic region, but blended for all ages and genders. Also, the rate was based on the AFDC-related eligibility group. Because the State is required to pay age and gender specific rates, and because the population covered under this waiver is limited to only adults who are not eligible for AFDC-related Medicaid, the State requests new budget neutrality targets for demonstration years four and five specific to the age and gender covered under the demonstration. The method for calculating the new age and gender rates is described below.

Calendar Year 1999 Base Period PMPM Cost

The base period cost of \$121.23 was developed consistent with the Wisconsin managed care rate setting methodology and payment structure at the time the waiver was submitted to CMS. This rate setting methodology relied on a single, aggregate capitated rate cell for both children and adults. In our negotiations with CMS, we made clear that our rates were aggregate and represented the estimate of the health care resource consumption for both adults and children. Wisconsin, consistent with the Balanced Budget Act of 1997, discontinued the single, aggregate payment methodology beginning in calendar year 2002 and restructured the rate-setting methodology to pay capitation rates using age and gender rate cells.

In order to ensure that the budget neutrality cap is being measured against the enrolled population covered by Title XIX expenditures during Demonstration years four and five, it is necessary to disaggregate the PMPM base period cost of \$121.23 into its actuarially equivalent adult only Title XIX cost component. The disaggregation is based on actuarially determined age and gender weighting factors as developed by our consulting actuaries Milliman USA. The factors are the same factors that are used in our rate setting methodology for our current BadgerCare managed care program capitation rates and are representative of the medical cost differences between adults and children.

Re-Calculating the Base Rate for Age Characteristics

The original waiver calculated a budget neutrality target for all populations served under the BadgerCare waiver, including children funded under Title XXI. Because neutrality is only measured against the Title XIX population, the budget neutrality target was understated for the covered population. However, the single aggregate capitation rate accurately reflected the premium structure in Wisconsin through March 2002.

Exhibit 1 re-calculates the blended managed care rate into an adult/child rate. This calculation multiplies enrollment in BadgerCare for calendar year 2001 by the age and gender factors that the State's consulting actuary, Milliman USA, developed for 2003 capitation rates. Next, the population by age and gender was multiplied by the 2003 equivalent cost for all individuals (\$153.73) to generate total costs for children (under 21) and adults (21 and over). These data created age and gender factors of 0.495 for children and 1.257 for adults.

Next, because the base rate of \$121.23 represented a greater percentage of children (46 percent children and 54 percent adults in the original waiver application), the base rate was adjusted to reflect the actual managed care enrollment of 34 percent children and 66 percent adults. Adjusting for this enrollment generated a cost per-member, per-month cost for adults in the base year of \$168.08. Trending this forward to year one of the demonstration at the waiver approved 3.48 percent generates a cost of \$171.00 per adult. Trending this forward to year four of the demonstration, at 3.48 percent, yields an average cost of \$189.48. The State is requesting that the budget neutrality limit for year four be amended to this cost of \$189.48 per person to reflect the required age and gender payment rates. Also, we are requesting that the year five budget neutrality limit be set at \$196.07, or the year four cost trended for one-year at 3.48 percent.

Summary of Expenditures for Demonstration Year One through Five

Exhibit 2 depicts total enrollment months and total expenditures for the Title XIX population. On January 18, 2001, a waiver amendment was granted that allowed the State to use Title XXI funds to pay for medical costs for adults with incomes over 100 percent FPL. As a result, the population covered under the Title XIX waiver changed in the middle of Demonstration year two from All Adults to only Adults with Incomes at or Below 100 percent FPL. For this reason, there are three populations in demonstration year two.

The projection for the fifth year uses the historical costs for the fee-for service population. For the managed care population, the trend is based on the expected managed care rate increases for calendar year 2004. This increase is expected to be 9.75 percent beginning May 1, 2004 for the remaining calendar year. This rate increase is necessary to sustain the BadgerCare managed care program. For calendar year 2003, managed care organizations serving BadgerCare recipients are paid an average of 14.5 percent less than the equivalent cost in fee-for-service. Continued low reimbursement will cause HMOs to withdraw from the program.

The chart compares the per-person cost for the demonstration population to the original budget neutrality limit for years one through three. In year four, the chart shows the re-calculated Adult Target per person cost for budget neutrality. This recalculation factors in the age of the covered population as well as the enrollment percentage in managed care and fee-for-service.

Using the adult only budget neutrality target beginning in demonstration year four, and continuing thereafter, the four-year summary of expenditures exceeds the budget neutrality target by \$18.9 million in total computable funds, or approximately \$11.0 million in federal funds. The projection through demonstration year five estimates total spending of \$9.0 million in federal funds in excess of the targets.

Demonstration Reconciliation

Following the close of waiver demonstration year five, the Wisconsin Department of Health and Family Services will provide CMS with the final computation of the total computable Title XIX funds spent in excess of the agreed to target limits contained in the attached spreadsheet. The final reconciliation of expenditures to target limits will be completed once all claims have been submitted and processed through the Medicaid paid claims system administered through the Department's Medicaid fiscal agent. Wisconsin Medicaid providers have twelve months to submit claims from the date of service. The final reconciliation will be completed when all claims have been submitted, verified, and final adjustments made.

10) Adequacy of Financing and Reimbursement

Three-Year Forecast

Exhibit 3 projects costs and enrollment for the three year extension of the waiver. The base per person expenditure projection in Exhibit 3 uses the most recent data, or demonstration year four. These costs are increased annually by the historical trend in fee-for-service expenditures. These costs are increased annually by the trend in cost of the BadgerCare HMO enrollees as certified by the consulting actuaries. These medical costs have increased an average of 11.7 percent annually.

This trend was used because managed care rate increases have not kept pace with health care cost trends. Managed care organizations are currently receiving 14 percent less than the equivalent cost if the enrollee was receiving services through the FFS system.

The budget neutrality targets in Exhibit 3 are trended based on these same historical costs. This trend of 11.7 percent is used in order to provide Wisconsin with sufficient capacity to increase managed care plan rates in order to account for increasing case-mix intensity and utilization. In addition, Wisconsin's BadgerCare managed care capitation rates are on the low end of what the Department's consulting actuaries will certify as being actuarially sound. The higher trends are required in order to assure that if actual health care cost trends continue to increase due to greater intensity and case-mix, we will not exceed the budget neutrality limits stipulated in the waiver extension.

Specifically, the actuarially calculated trends for the BadgerCare managed care program compared to the approved rate increase over the past two years and projected to 2004 are as follows:

	2002	2003	2004	Three Yr. Avg.
<i>HMO Cost Trend</i>	<i>18.4%</i>	<i>10.3%</i>	<i>6.5%</i>	<i>11.7%</i>
<i>HMO Rate Increase</i>	<i>4.9%</i>	<i>4.2%</i>	<i>6.5%</i>	<i>5.2%</i>
<i>Variance</i>	<i>(13.5%)</i>	<i>(6.1%)</i>	<i>(0%)</i>	<i>(6.5%)</i>

The large variance between actual trend and the funded rate increases has created unsustainable discounts that have put significant strains on participating health plans and resulted in reductions in service area coverage. Service area reductions mean more BadgerCare eligible persons will be served at higher costs under fee-for-service. Further, the participating health plans have made clear that current discounts and under funding of the actual medical cost trend will mean increasing enrollment limits and additional reductions in service area. We also anticipate that if the gap between the estimated equivalent costs and the capitation rates cannot be significantly bridged, health plans will refuse to participate entirely. This would result in the entire BadgerCare program for both adults and children converting to fee-for-service.

The current waiver had a five-year health care trend rate based on prior experience that was not commensurate with actual health care cost inflation that occurred during the waiver period. This resulted in Wisconsin exceeding the budget neutrality limits and threatening the continued participation of health care plans in the BadgerCare program.

The requested budget neutrality targets will protect Wisconsin from unrealistic expectations resulting from unreasonably low targets.

11) Budget Neutrality for Three-Year Extension

For the initial five-year demonstration, a settlement of budget neutrality costs will be made after all claims for the demonstration years one through five have been submitted and paid. Anticipating a payment to the federal government by the State, this payment will be made in federal fiscal year 2006.

For the second part of the demonstration, a separate calculation of budget neutrality will be made for years six through eight. If actual costs exceed budget neutrality over this three-year period, another settlement will be made after the end of the eighth year.

Exhibit 1
Calculating Adult/Child Rates for 1999 BadgerCare Waiver

Dis-aggregating Adult and Child Monthly Cost for CY 1999

CY 2001 HMO Enrollment

Year	Aid Cat.	Age	Gender	Member Months	Percent of Total
2001	BC	Age 0-14	A	164,729	24.0%
2001	BC	Age 15-20	F	39,982	5.8%
2001	BC	Age 15-20	M	26,538	3.9%
2001	BC	Age 21-34	F	187,833	27.4%
2001	BC	Age 21-34	M	62,788	9.1%
2001	BC	Age 35-44	F	100,384	14.6%
2001	BC	Age 35-44	M	50,612	7.4%
2001	BC	Age 45+	F	29,062	4.2%
2001	BC	Age 45+	M	24,486	3.6%
Total Member Months				686,414	100.0%

		(a)	(b)	(a) x (b)
Age	Gender	Percent of Total	Age/Gender Factor	Net Cost by Age/Gender
Age 0-14	A	24.0%	0.413052649	.099126402
Age 15-20	F	5.8%	0.804702322	0.046872016
Age 15-20	M	3.9%	0.538059509	0.020802349
Age 21-34	F	27.4%	1.176544408	0.321954194
Age 21-34	M	9.1%	0.612883756	0.056062005
Age 35-44	F	14.6%	1.567013774	0.229166524
Age 35-44	M	7.4%	1.084671661	0.079977101
Age 45+	F	4.2%	1.915699327	0.081108564
Age 45+	M	3.6%	1.820200971	0.064930845
				1.00

Calculating Total Costs for Population by Age

2003 Equivalent Cost (Milliman Rate Paper)	\$153.73	
Total Cost using a single rate for Children	\$17,601,221	Enroll Mos. X Net Cost x 2003 Equivalent Cost
Total Cost using a single rate for Adults	\$87,921,203	Enroll Mos. X Net Cost x 2003 Equivalent Cost

Calculating PMPM Cost by Age Group (Total Costs divided by member months)					
					Age Factor
				% of Total Population Enrolled	(Age Cost/Equiv Cost)
2003 PMPM Child (Single rate costs/Eligible Months)		\$76.11	33.7%	0.495	
2003 PMPM Adult (Single rate costs/Eligible Months)		\$193.16	66.3%	1.257	
			\$153.73		
From Waiver Application:		CY 1999			
Budget Neutrality Limit		\$121.23			
Estimated Enrollment – Children		46%			
Estimated Enrollment – Adults		54%			

Exhibit 2
Summary of Expenditures and Enrollment Months

Wisconsin BadgerCare Budget Neutrality

	Demo Yr 1	Demo Yr. 2	Demo Yr. 3	Demo Yr. 4	Demo Yr. 5
Enrollment Months (FFS)	162,065	141,373	94,846	98,032	99,637
Enrollment Months (MC)	200,630	203,689	259,897	255,376	269,389
		119,054			

FFS Expenditures	\$31,901,797	\$28,207,474	\$19,367,515	\$23,225,044	\$24,064,699
MC Expenditures	\$24,333,315	\$34,028,898	\$34,466,862	\$41,141,512	\$44,863,748

PMPM Calculations - Actual					
FFS	\$196.85	\$199.53	\$204.20	\$236.91	\$241.52
Managed Care	\$121.28	\$105.44	\$132.62	\$161.10	\$166.54
Combined	\$155.05	\$134.10	\$151.76	\$182.13	\$186.78
<i>Combined Annual Growth Rate</i>		-13.51%	13.17%	20.02%	2.56%

		3.48%	3.48%	3.48%	3.48%
Budget Neutrality Agreement	\$123.33	\$127.62	\$132.06	\$189.47	\$196.06
Target Aggregate	\$44,731,174	\$59,230,484	\$46,847,361	\$66,960,214	\$72,352,550
Actual Aggregate	\$56,235,112	\$62,236,372	\$53,834,377	\$64,366,556	\$68,928,447
(Over)/Under BN Cap	(\$11,503,938)	(\$3,005,888)	(\$6,987,016)	\$2,593,658	\$3,424,103

(\$15,479,081)

Exhibit 3
Enrollment and Medical Cost Forecast 2006 through 2008

Wisconsin BadgerCare Projected Budget Neutrality
For the Three Year Extension of the Waiver Demonstration

	Demo Yr. 6	Demo Yr. 7	Demo Yr. 8	Total
Enrollment Months (FFS)	102,344	105,125	107,982	
Enrollment Months (MC)	276,709	284,227	291,950	
FFS Expenditures	\$27,610,569	\$31,679,050	\$36,347,176	
MC Expenditures	\$51,474,501	\$59,059,174	\$67,761,606	

Costs trended at 3 year average cost increase for an HMO enrollee.

WI Proposal - President's Budget	11.7%	11.7%	11.7%	
Blended Targets (FFS/MC)	\$219.00	\$244.63	\$273.25	
Target Aggregate	\$83,013,741	\$95,245,756	\$109,280,469	
Actual Aggregate	\$79,085,094	\$90,738,225	\$104,108,742	
(Over)/Under Proposed BN	\$3,928,647	\$4,507,530	\$5,171,727	\$13,607,904
Trend Rate for Expenditures	11.7%	11.7%	11.7%	

In Years 6 through 8, the budget neutrality target and the project expenditures are trended at 11.7% per year. This is the average cost increase over the past three years for BadgerCare eligibles enrolled in an HMO. Actual capitation rate increases over the past 3 calendar years have averaged only 5.2%.

Assumptions:

Enrollment – Enrollment forecast for 2004 and beyond is based on state biennial budget estimate of parents with incomes at or below 100 percent of the FPL separated by fee-for-service (FFS) and managed care.

Waiver trend

- The trend for projected costs in years six through eight is based on the three-year average cost increase of BadgerCare HMO enrollees. The trend of 11.7 percent is developed by a certified actuary and does not represent the capitation rate increases. Capitation rate increases have averaged only 5.2 percent.
- The demonstration year five cost trend for managed care includes no rate increase for the first four months of calendar year 2004 followed by a 9.75 percent rate increase for the last two months of demonstration year five. The FFS trend for year five is based on the four-year trend.
- The base FFS cost is a blend of the year three FFS cost trended for two years and the year four FFS cost trended for a single year.

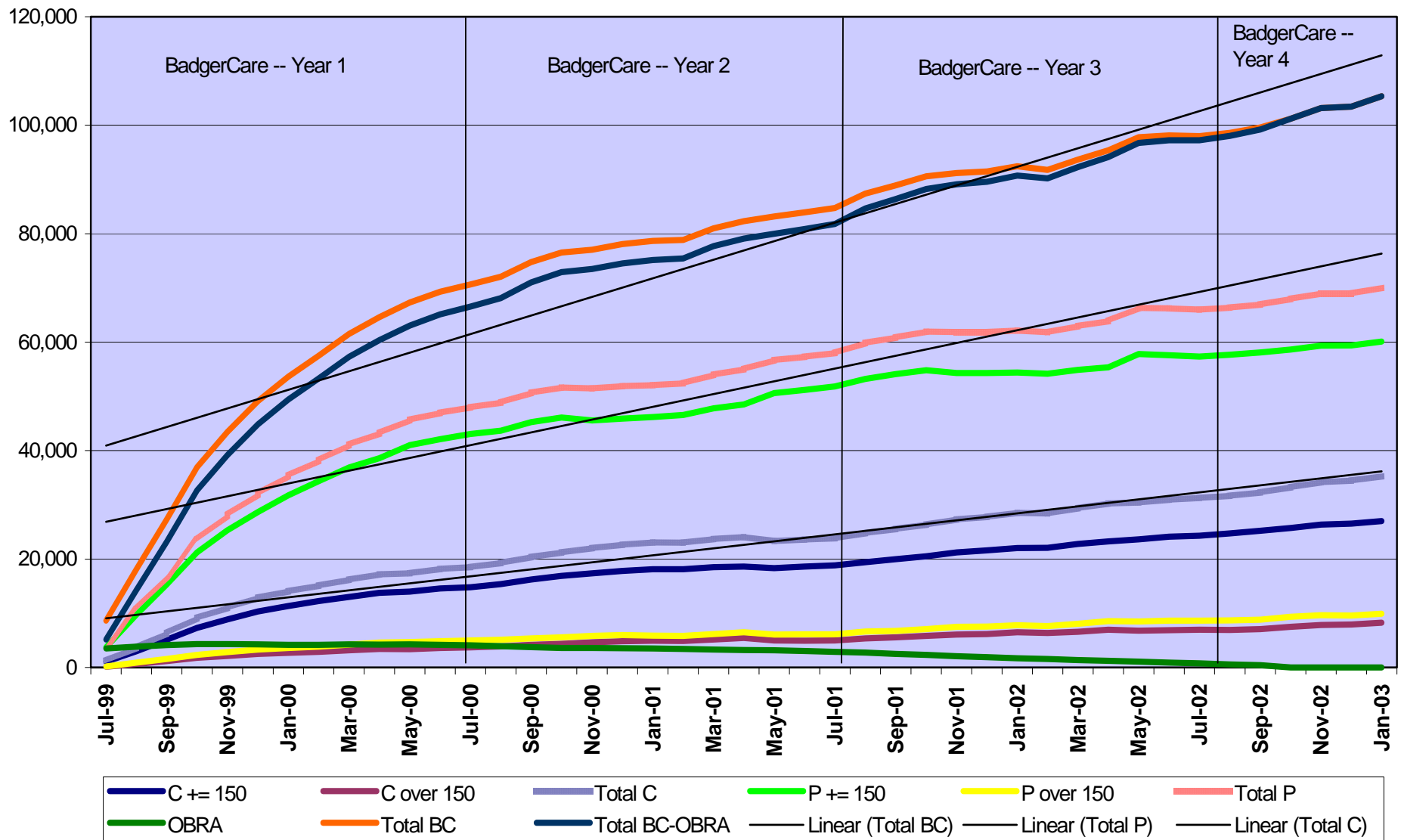
Appendix A

The graph on the following page shows enrollment in BadgerCare from July 1999 to February 2003. Following the steep uptake in enrollment during the first year of BadgerCare, the most notable element of this enrollment graph is the lack of sharp peaks or troughs. Rather, enrollment in BadgerCare, as indicated by the respective trend lines, is that enrollment has grown at a fairly steady pace. According to the data, enrollment in BadgerCare has increased at a monthly average of 2,286 people. If the high growth first year is subtracted from this total, average monthly enrollment increased by 1,230 people. We believe it is this figure that represents a more accurate portrayal of average enrollment growth in BadgerCare.

The monthly average enrollment declined in almost each year of the BadgerCare program. For example, in the high growth start up year of BadgerCare from July 1999 through June 2000, enrollment in BadgerCare increased by an average of 5,454 people per month. In the second year, from July 2000, to June 2001, this growth dropped to an average enrollment increase of 1,309 people per month. In the third year of BadgerCare, average enrollment increased slightly to 1,361 people per month. The first eight months of the fourth year of BadgerCare saw enrollment growth again slowing to an average enrollment gain of 1,018 people per month.

The graph demonstrates that, overall, enrollment growth in BadgerCare has remained rather constant. While at some point we expect to see monthly BadgerCare enrollment growth stabilize, we have not seen indications of this stabilization yet.

BadgerCare Enrollment **July 1999 to January 2003**



Appendix B

Appendix C

Appendix D

Appendix E

Appendix F